College Station Urology
Dr. Evan Lacefield

Today's Date: _____

PCP: _____

1602 Rock Prairie Rd, Suite 4000
College Station, TX 77845
Phone: 979-696-5505
Fax: 979-696-1287

Patient Information

Mr. Miss Marital Status (Circle One)
Mrs. Ms. Single / Married / Div / Sep / Widow

Last Name: First: MI

Is this your legal name? Y or N If not, what is your legal name: _____

Date of Birth _____ Age _____ Sex: Male Female

Street Address: City: State Zip

( ) Home Phone ( ) Cell Phone ( ) Other Phone

Email: Referred By:

Responsible Party Information

Person Responsible: DOB: Phone:

Address (if different): City: State Zip

Employer: Employer Address: Employer Phone:

Insurance Information

If insurance card is available, please hand it to the receptionist and you may skip this section.

Policy Holder: DOB: Group ID: Policy no:

Patient's Relationship: Self Spouse Child Other

Policy Holder: DOB: Group ID: Policy no:

Patient's Relationship: Self Spouse Child Other

Emergency Contact

Name: Relationship: Day Phone:

PATIENT'S OR AUTHROIZED PERSON'S SIGNATURE:
I authorize the provider or insurance company to release any information required for this claim. I authorize my insurance benefits to be paid directly to College Station Urology/CHS. I understand that even though I have assigned benefits to be paid directly to College Station Urology/CHS, I am still responsible for the entire bill.

Signature: _____ Date: _____

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NAME:

PATIENT HISTORY

DRUG ALLERGIES: ☐ No Known Drug Allergies

REACTION:

LATEX ALLERGY: ☐ YES ☐ NO

Are you under the care of a primary physician? ☐ YES ☐ NO Name:

Have you ever had an adverse reaction to anesthesia? ☐ YES ☐ NO

Medical History:

☐	Asthma or COPD	☐	Hypertension/High Blood Pressure
☐	Cancer (Type_____)	☐	Bladder Cancer
☐	Concussions	☐	Liver Disease/Hepatitis
☐	Depression/Anxiety	☐	Lung Disease/TB
☐	Diabetes	☐	Seizures
☐	Enlarged Prostate	☐	Sleep Apnea
☐	Gout/Arthritis	☐	Stomach/GERD/Bowel Problems
☐	Urinary/Fecal Incontinence	☐	Prostate Cancer
☐	Headaches/Migraines	☐	Thyroid Disorder
☐	Heart Disease	☐	Kidney Stones
☐	BLEEDING DISORDERS/ANEMIA	☐	DVT/CLOTS/CIRCULATORY
☐	HIV/AIDS	☐	Urological Disease
☐	Kidney Cancer	☐	Other:_____

Immunizations	Date
Tetanus	
Flu	
Pneumovax	
Zostavax (Shingles)	

Preferred Pharmacy:_____

Preferred Lab:_____

Medications (List ALL current prescriptions and over-the-counter medications) ☐ Not currently taking medication

Name	Dosage	Name	Dosage

PAST SURGICAL HISTORY: (List ALL procedures and type regardless of date) ☐ No Previous Surgeries

SOCIAL HISTORY

Do you smoke or use tobacco products?	Never	In the Past	Occasionally	Reguarly	Quantity:	Packs/Day
Do you drink Alcohol?	Never	In the Past	Occasionally	Reguarly	Quantity:	Day/Week
Do you use any street drugs? (i.e. marijuana, cocaine, methamphetamine)	Never	In the Past	Occasionally	Reguarly		
How much caffiene do you consume?	Never	In the Past	Occasionally	Reguarly	Quantity:	Day/Week

FAMILY MEDICAL HISTORY: (Biological)

Check any of the following condiions that a family member currently has or has had in the past, then indicate who in your family has/had the condition. (1st or 2nd degree relatives only: Mother, Father, Sibilings, and Grandparents)

☐	Anesthetic Complications	☐	High Cholesterol
☐	Birth Defects	☐	Kidney Disease
☐	Bleeding Disorder	☐	Lung Cancer
☐	Blood Clots	☐	Osteoporosis
☐	Breast Cancer	☐	Ovarian Cancer
☐	Cervical Cancer	☐	Pancreatic Cancer
☐	Colon Cancer/Polyps	☐	Psychiatric Disease/Depression
☐	Diabetes	☐	Seizures
☐	Heart Disease	☐	Stroke
☐	High Blood Pressure	☐	Skin Cancer
☐	Uterine Cancer	☐	Thyroid Disease
☐	Prostate Cancer	☐	Kidney Cancer
☐	Bladder Cancer	☐	Kidney Stones
☐	Urological Disease	☐	Other:_____

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ALL PROFESSIONAL FEES ARE DUE AT THE TIME OF SERVICE, UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

Assignment of Benefits & Financial Agreement

As a courtesy, College Station Urology will file an insured person's insurance if proper information is received. I hereby authorize payment of medical benefits to be paid directly to College Station Urology for services described on the claim form. I am responsible for co-pays, deductibles, non-covered services, co-insurance and items considered "not medically necessary" by the insurance company. For unpaid claims over 45 days, it is my responsibility to follow up with the insurance company and the balance due is considered due to payable. It is my responsibility to notify our front desk staff or any insurance to address the changes. I will be responsible for any charges that occur if College Station Urology is not notified. Any debt incurred to collect a debt will be at the expense of the patient/ responsible party.

Consent for Treatment

I hereby authorize College Station Urology to evaluate, treat and perform diagnostic tests and office procedures that the physician deems necessary. My medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility. My medical information may also be disclosed to healthcare students, interns, and residents.

Release of Information

I hereby authorize any and all physicians, surgeons, and doctors who have examined, treated or x-rayed me, and all hospitals in which I was ever a patient, to furnish to College Station Urology of College Station, Texas or the bearer hereof, all reports, records, x-rays, laboratory reports and other data or information in their possession or control, subject to my physical and mental condition, medical history, treatment, or diagnosis (past, present, and future) and to permit them to examine such records, xx-rays, reports, and medical information, and hereby authorize them to permit the making of copies thereof, or to furnish copies thereof, thereby revoking all other medical authorizations signed by me in the past. This authorization shall remain in effect until revoked by me in writing and may be evidence by a photo-static or facsimile copy thereof.

Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use and electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

_____

Right to Request Confidential Communication

I have the right to request that College Station Urology communicate with me about medical matters in a certain way or at a certain location. To request confidential communications, I must make my request in writing. I shall be asked the reason for my request. College Station Urology will accommodate all reasonable requests. My request must specify how or where I wish to be contacted.

Please indicate the methods and/ or locations by or at which we may contact you.

Telephone:_____ Mailing Address:_____ Other: _____

Right to Request Restrictions

I have a right to request a restriction or limitation on the medical information used or disclose about me for treatment, payment or health care operations. I also have the right to request a limit on the medical information disclosed about me to someone who is involved in my care or the payment for your care, like a family member.

Please check one:

- ☐ No Restrictions
- ☐ Restrictions: _____

☐ I am 18 years old or older and authorize the release of my information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____
Print Patient Name

_____ _____ _____
Signature of Patient or Patient Representative *Relationship* *Date*

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices.

Printed Name of Patient: _____

Signature: _____

Authority to Sign if not Patient: _____

Date: _____

For Office Use Only:

The Patient was provided a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt. An acknowledgement signature was not obtained because:

_____

_____

Signature of Office Representative: _____

Date: _____